

code does not describe a mental disorder; and disagreed with our statement in the proposed rule that code 780.02 was similar to codes 293.81 and 293.82. The commenters further stated that they disagreed with our assertion that many patients with a diagnosis of transient alteration of awareness are treated in psychiatric facilities.

Response: Our review of claims data indicates that code 780.02 is a frequent diagnosis for patients admitted to psychiatric hospitals. Many patients are likely to present with transient alteration of awareness at the time of admission to a psychiatric hospital. The cause of this transient alteration is likely to be diagnosed during the stay, leading to the assignment of another, more specific principal diagnosis.

However, in many patients, this is not the case, and no underlying cause for the transient alteration of awareness is determined. When a more definitive diagnosis cannot be made, the patient is left with the diagnosis of alteration of awareness. We recognize the difficulty in assigning symptoms such as these to the most appropriate DRG. However, we will note that the average charges for DRG 23 (where the code is currently assigned) and DRG 429 are similar.

Therefore, we are proceeding with the assignment of code 780.02 to DRG 429 based on a review of psychiatric hospital data as well as a clinical comparison of cases already assigned to DRG 429.

4. MDC 5 (Diseases and Disorders of the Circulatory System)

a. DRG 478 (Other Vascular Procedures With CC) and DRG 479 (Other Vascular Procedures Without CC)

Code 37.64 (Removal of heart assist system) in DRGs 478 and 479 describes the operative, as opposed to bedside, removal of a heart assist system. Based on comments we received suggesting that code 37.64 was inappropriately assigned to DRGs 478 and 479, we reviewed the MedPAR data for both DRGs 478 and 479 and DRG 110 (Major Cardiovascular Procedures With CC) and DRG 111 (Major Cardiovascular Procedures Without CC) to assess the appropriate assignment of code 37.64.

We found that there were only 17 cases of code 37.64 in DRGs 478 and 479, with an average length of stay of 14.1 days and average charges of \$105,153. There were a total of 90,591 cases in DRGs 478 and 479 that did not contain code 37.64. These cases had an average length of stay of 6.6 days and average charges of \$31,879. In DRGs 110 and 111, we found an average length of stay of 8.1 days, with average charges of \$54,653.

We proposed to remove code 37.64 from DRGs 478 and 479 and reassign it to DRGs 110 and 111. The surgical removal of a heart assist system is a major cardiovascular procedure and, therefore, more appropriately assigned to DRGs 110 and 111. Accordingly, we believe this DRG assignment for this procedure is more clinically and financially appropriate.

We received two comments in support of this change. Therefore, we are adopting as final our proposal to remove code 37.64 from DRGs 478 and 479 and assign it to DRGs 110 and 111.

b. DRGs 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) and 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization)

(1) Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction

Prior to the publication of the proposed rule, we received a recommendation to modify DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) and DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization) so that these DRGs are split based on the presence or absence of acute myocardial infarction, heart failure, or shock as a principal diagnosis. We note that the increased cost of treating cardiac patients with acute myocardial infarction, heart failure, or shock is recognized in the payment logic for pacemaker implants (DRG 115 (Permanent Cardiac Pacemaker Implant With Acute Myocardial Infarction, Heart Failure or Shock, or AICD Lead or Generator) and DRG 116 (Other Permanent Cardiac Pacemaker Implant)).

We examined FY 2002 MedPAR data regarding the number of cases and the average charges for DRGs 514 and 515. The results of our examination are summarized in the following table.

DRG	Number of cases	Average charges	With AMI, heart failure, or shock count	Average charges
514	16,743	\$97,133	3,623	\$120,852
515	4,674	76,537	935	84,140

A cardiac catheterization is generally performed to establish the nature of the patient's cardiac problem and determine if implantation of a cardiac defibrillator is appropriate. Generally, the cardiac catheterization can be done on an outpatient basis. Patients who are admitted with acute myocardial infarction, heart failure, or shock and have a cardiac catheterization are generally acute patients who require emergency implantation of the defibrillator. Thus, there are very high costs associated with these patients.

We found that the average charges for patients with cardiac catheterizations who also were admitted with acute myocardial infarction, heart failure, or

shock were \$120,852, compared to the average charges for all DRG 514 cases of \$97,133. Therefore, we proposed to split DRG 514 and create a new DRG for patients receiving a cardiac defibrillator implant with cardiac catheterization and with a principal diagnosis of acute myocardial infarction, heart failure, or shock.

Patients without cardiac catheterization generally have had the need for the defibrillator established on an outpatient basis prior to admission. We found 935 cases with acute myocardial infarction, heart failure, or shock, with average charges of \$84,140. The average charges for all cases in DRG 515 were \$76,537. Because of the

relatively small number of patients and the less-than-10-percent charge difference for patients in DRG 515 who have acute myocardial infarction, heart failure, or shock, we did not propose to create a separate DRG for patients with a cardiac defibrillator implant without cardiac catheterization with acute myocardial infarction, heart failure, or shock.

Specifically, we proposed to create two new DRGs that would replace the current DRG 514. We indicated that the two proposed new DRGs would have the same procedures currently listed for DRG 514, but would be split based on the presence or absence of acute myocardial infarction, heart failure, or